Future Direction of the Health Care System

... establishing District Health Authorities

NOVA SCOTIA

Department of Health
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INTRODUCTION

On October 21, 1999, Health Minister Jamie Muir announced that effective immediately, governance of the four Regional Health Boards would be transferred to the Department of Health.

This decision is the Government of Nova Scotia's first step towards establishing a more community-responsive health care system that will see District Health Authorities established in the province. District Health Authorities will be smaller than the current Regional Health Boards, and they will have formal links to Community Health Boards.

As Nova Scotia takes action to confront the challenges created by the rising costs of health care and the increasing demands for services, we must not lose sight of the hard work and energy that the Regional Health Board members and staff have devoted to the current health care system. Their accomplishments will not be lost.

The input and expertise of many health care providers will be required to restructure the health care system. In addition, the involvement and collaboration of the Department of Health, Regional Health Boards, Non-Designated Organizations, Community Health Boards and other stakeholders will be vital to the successful implementation of the required changes.

This document outlines the process that will guide the transition to the new structure, a process that will take about a year to implement. In proceeding with a smooth transition, structural and delivery changes will be implemented in a manner that ensures the following:

- quality patient care
- continuity of health care delivery
- minimal disruption for health board employees
- involvement of staff and health care providers at all levels of the health care system
- retention of current efficiencies gained in the regional system.

THE FRAMEWORK FOR CHANGE

PARAMETERS FOR RESTRUCTURING THE HEALTH CARE SYSTEM

1. The Minister retains overall accountability for the health care system and will continue to delegate responsibility to the Department of Health (DoH) for setting provincial direction, monitoring and evaluating standards, funding the health care system, and managing and delivering those services not devolved to the District Health Authorities (DHAs). The Department of Health will develop and implement appropriate controls to ensure the continued delivery of quality care and appropriate financial management within each district.

2. During the transition from RHBs to DHAs, the governance function of the Regional Health Boards will be transferred to the Department of Health. The Regional Health Boards, as corporate entities, and their Chief Executive Officers will remain in place during the transition period.

3. DHAs will be accountable to the Minister of Health. DHAs will manage and deliver the health care services currently provided by the RHBs and will integrate home care and long term care at the district and community levels. The appropriate management models for delivery of these and other health care services will be assessed before the responsibility for integrating them is transferred to the DHAs. Shared services will be emphasized to retain current efficiencies in service delivery.

4. There will be nine (9) DHAs that will be aligned, in general, along county lines. The DHAs will be based in the areas primarily served by existing regional hospitals, and they will enjoy the same historical relationships, catchment areas, and referral patterns.

5. Two-thirds of the DHA membership will be selected by Community Health Boards (CHBs) through a community-based process that is open to the public. The remaining one-third of the members will be appointed by the Minister of Health based on a public advertisement requesting an expression of interest in serving on a DHA.

6. The provision of secondary care services will not be identical in each district or facility. The DoH will establish a master clinical service delivery plan, in collaboration with the health organizations, that will identify the specific secondary and tertiary care services to be delivered in each facility while ensuring that all Nova Scotians have access to these services.

7. Community Health Boards will be legislated in their mandate of assessing community needs and establishing a community health plan. Each plan will address the coordination of primary health care and identify overall strategies to improve the health of the community.

8. The IWK/Grace and the QEII Health Sciences Centre will become known as Provincial Health Care Centers (PHCCs). While it is acknowledged that these organizations have a unique role to play in the provision of tertiary care services for Nova Scotia and the Maritimes, they also provide primary and secondary services. These organizations will therefore engage in joint service planning for primary and secondary care services with the District Health Authority in the Halifax area.

9. The Cape Breton Health Care Complex (CBHC) will be part of a District Health Authority for Cape Breton County. The CBHC and the Eastern Regional Health Board will collaborate on establishing DHA boundaries in Cape Breton.

10. The Nova Scotia Hospital (NSH) will participate in the transition process, concurrent with the provincial mental health review. Recommendations on the delivery of mental health services will be incorporated into the clinical service plan for DHAs.

11. During the transition phase, health care providers will be engaged in planning and implementing the change to DHAs.

12. Health care management personnel will be maintained within the system, where possible and required. Existing CEOs of the RHBs will be invited to participate in the transition process.

13. Home care and long term care services will be integrated into the continuing care sector, at the district level. Single entry access to these services will be established, pending the outcome of current discussions between the Departments of Health and Community Services with the participation of the Continuing care sector.

14. Efficiencies gained in regionalization will be retained wherever possible. Opportunities for further partnerships and shared services will be encouraged and/or mandated. In areas where service division between the DHAs is not appropriate, service agreements will be established.

15. A system-wide plan for supporting legislation, a new funding strategy, a labor strategy, and a provincial information network, will all be required as enablers to this structural change.

THE FOCUS OF CHANGE

- Improve the health status of Nova Scotians
- Make the system more responsive to community needs
- Improve the integration and quality of health care services
- Integrate service planning and financial planning throughout the system
- Make the system more accountable to the public
- Make effective use of limited resources

EMPHASIS ON PATIENT CARE

The overall objective of the community-based health care system is to provide Nova Scotians with integrated, high-quality services, delivered by the right care giver, in the most appropriate location, in the most cost-effective way.

The health services offered will promote health, prevent illness, and provide treatment. Appropriate access to community-based primary care services and specialty services (secondary and tertiary care) will be provided. Services available at the district and community levels will include home care, public health, mental health, drug dependency, and emergency services, as well as the services provided by district hospitals, community hospitals, and homes for special care.

There will be nine District Health Authorities serving geographic areas smaller than the previous regions. These new structures will make the system more responsive to the needs of Nova Scotians and enhance the efforts that are already under way to better integrate the province's health care services.

District Health Authorities will help Nova Scotians obtain the services that best meet their needs. They will also strengthen the relationships between the individuals, providers, and health care organizations to deliver effective health services.

The types of community and regional services located in districts throughout the province will vary. A master clinical service plan will be prepared to identify the secondary services and district-level tertiary services that will be provided in each district and facility. The plan will ensure that all Nova Scotians have reasonable access to the health services they require. The clinical service plan will be developed by the Department of Health in collaboration with health organizations and providers. Decisions that are made during the service-planning process will be based on quality of care, evidence, and best practice.

At the provincial level, the Departments of Health and Community Services, with the participation of the continuing care sector, are examining the delivery of continuing care services. These discussions will be linked to the transition process. One option being considered, is the development of specific service access points that would make it easier for Nova Scotians to obtain certain services such as home care and long term care. This type of access to an integrated array of health care services is referred to as single entry access.

IMPLEMENTATION STEPS

The following are the first of many steps required to implement the new structure:

PHASE I

- RHB governance transferred to the Deputy Minister of Health, October 1999.
- RHB CEOs and staff will continue to manage and oversee the services provided by Regional Health Boards.
- Administrative staff from the RHBs will work with Regional Directors from the DoH to address the details of transition.
- CEO and Board of the CBHC will work with the Regional Director from the DoH to facilitate the transition to a Cape Breton DHA.
- CEOs and Boards of the IWK/Grace and QEII will be required to participate in clinical service planning for the Halifax DHA.
- A transition unit will be established in the DoH
- RHBs, NDOs, and stakeholder groups will provide advice to the Department of Health on the critical decision points during transition.

PHASE II

The DoH will lead a provincial process which includes:

- Determining the boundaries for districts
- Preparing a master clinical services plan for the province
- Clarifying the role of Provincial Health Care Centers in the new structure
- Preparing budgets and business plans for DHAs, PHCCs, NSH and DoH
- Legislating CHBs
- Working with DHA boards to establish the administrative structure
- Developing a labor strategy to facilitate employee transition to DHAs
- Fostering linkages with the Provincial Health Council, professional associations, charitable organizations, and other key stakeholders in the process.

PHASE III

Ongoing evolution of DHAs will include the following:

- District Health Authorities will assume governance and management on October 1, 2000
- Time lines for devolution of home care and long term care will be established.

CLEAR ROLES IN THE RESTRUCTURED SYSTEM

To improve service planning, responsiveness, and accountability, there will always be a need to balance community, district, and provincial responsibilities. The following information, including Table 1 on page 8, clarifies specific roles and responsibilities in the new structure.

Community Health Boards will be legislated to assess local needs, develop plans to coordinate primary health care and identify ways to improve the overall health of the community. CHBs will be collectively supported by the District Health Authorities in fulfilling this mandate. Community health plans will encompass health care services as well as broad community health programs. The plans will be submitted to the DHAs for inclusion in the district business planning process.

District Health Authorities will integrate health care services within the district. They will also govern, plan, manage, deliver, monitor, evaluate and fund the health services devolved to them and support CHBs in fulfilling their mandate. DHAs will be responsible for coordinating the relationships of patients, clients, providers, and organizations. They will help patients and clients navigate through the system to receive easier access to effective quality service, provided by the right care giver, in the most appropriate location, in a cost-effective manner. The nine District Health Authorities will be responsive to community needs while also planning and providing services in conjunction with the Provincial Health Care Centers.

Provincial Health Care Centers (IWK/Grace and QEII) will govern, plan, manage, deliver, monitor, and evaluate specialty and provincial programs, and health services provided through their organizations. Planning for primary and secondary care services provided to residents in the catchment area of the Halifax DHA will be integrated at the local DHA level.

The Minister of Health will continue to be ultimately accountable for the health care system in Nova Scotia, for all programs, services and facilities funded by the Department of Health and for the expenditure of the health care budget. The Department of Health, as the agent of the Minister, will set provincial direction and policy, establish, monitor and evaluate provincial standards, manage those health services not devolved to the district, and fund the health care system.

The Provincial Health Council will advise the government, through the Minister of Health, in the development of a comprehensive health policy and in setting the overall direction of the health system. The Council will promote the use of Nova Scotia's Health Goals as an essential tool for achieving health and well being for Nova Scotians and their communities.

TABLE 1: STAKEHOLDER ROLES

FUNCTION	DoH PROVINCIAL ROLE	DHA AND PHCC INTEGRATION & MANAGEMENT ROLE*	COMMUNITY HEALTH BOARDS
PLANNING	Establish provincial strategic direction.	Contribute to provincial strategic plan and develop organizational strategic plan that supports provincial direction and priorities while recognizing and reflecting district/organization and community needs.	Conduct community needs assessment and provide the information to the district. Prepare a community health plan for integration into district business plan.
POLICY	Establish provincial policy.	Provide advice during policy development and implement provincial policies.	Provide advice during policy development and implement provincial policy.
HUMAN RESOURCES	Develop broad provincial human resource policy and overall human resource plan for the system.	Contribute to the development of provincial human resource plan and develop district human resource plans that fit provincial direction and recognize specific human resource needs in the districts.	Identify primary health care human resource needs of the community and provide recommendations to the district.
INFORMATION NETWORK (technology, infrastructure, & management of information)	Develop system-wide plan for provincial information network.	Contribute to provincial information network plan and develop an implementation strategy for the organization that is consistent with the provincial plan.	Use information to assist in planning.
FUNDING	Develop provincial funding methodology, approve organizations' budgets; monitor expenditures, merge DHA/PHCC/DoH into overall provincial health budget.	Prepare DHA and PHCC budgets within the provincial business plan and government parameters; manage funds allocated and report back; integrate the district business plans with community health plans.	Recommend priorities for primary health care services to the district.
SERVICES (standards, monitor, and evaluate)	Identify services to be delivered; manage those services not yet devolved; set provincial standards; monitor standards; and evaluate at a provincial level, etc.	Manage the services under the DHA and PHCC organizations; participate extensively in the development of provincial service standards; monitor and evaluate services provided by the organization.	

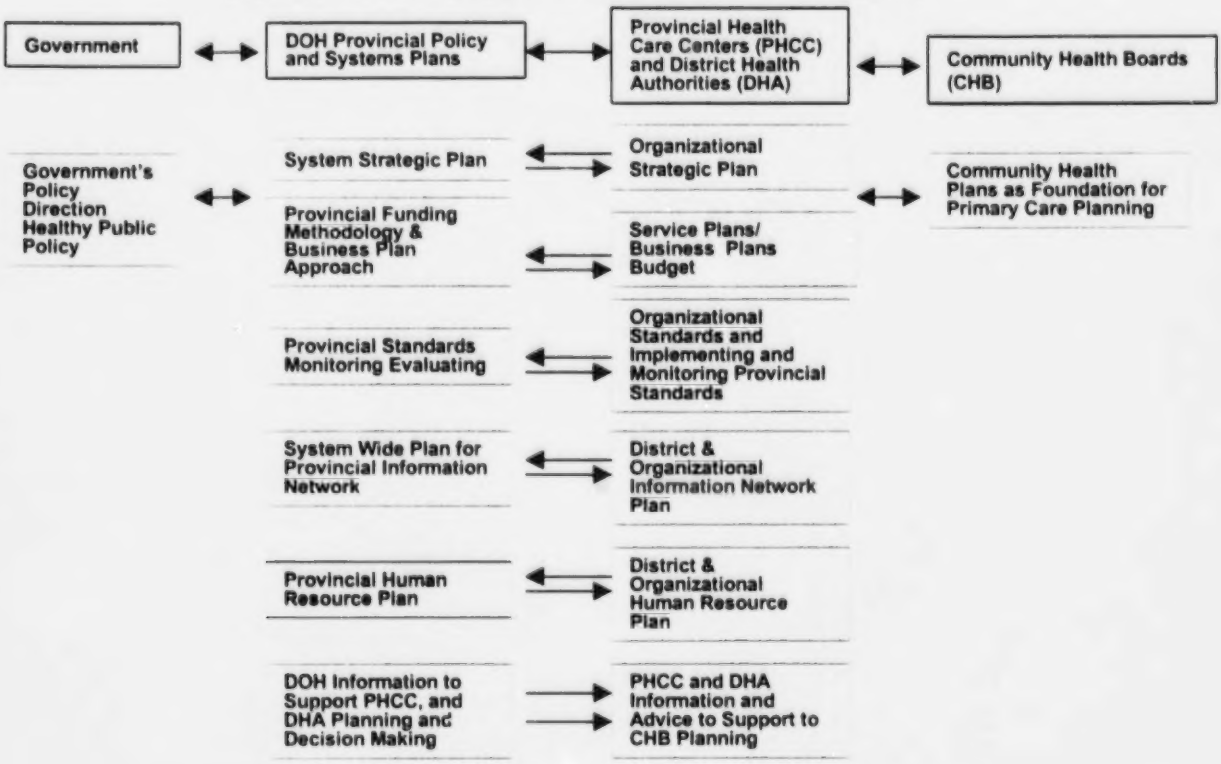
*All DHA and PHCC plans must be consistent with the direction of provincial plans.

PLANNING RELATIONSHIPS IN THE RESTRUCTURED SYSTEM

Planning in the restructured system will be an interactive process. Community Health Boards will prepare community health plans for submission to the District Health Authorities. The District Health Authorities will develop strategic plans and organizational business plans that incorporate the community health plans. These plans will be consistent with the system strategic plan and business planning framework developed by the Department of Health and is linked to the government's overall business planning process.

Figure 1, summarizes the key components of the provincial planning framework for the health care system.

FIGURE 1: PROVINCIAL PLANNING FRAMEWORK


Government
DOH Provincial Policy and Systems Plans
Provincial Health Care Centers (PHCC) and District Health Authorities (DHA)
Community Health Boards (CHB)
Government's Policy Direction Healthy Public Policy
System Strategic Plan
Organizational Strategic Plan
Community Health Plans as Foundation for Primary Care Planning
Provincial Funding Methodology & Business Plan Approach
Service Plans/ Business Plans Budget
Provincial Standards Monitoring Evaluating
Organizational Standards and Implementing and Monitoring Provincial Standards
System Wide Plan for Provincial Information Network
District & Organizational Information Network Plan
Provincial Human Resource Plan
District & Organizational Human Resource Plan
DOH Information to Support PHCC, and DHA Planning and Decision Making
PHCC and DHA Information and Advice to Support to CHB Planning

TRANSITION UNIT AND PLANNING TEAMS

Transition Unit

In keeping with the need to facilitate the planning process for system-wide change, the Department of Health has established a transition unit to coordinate transition activities across the province and to establish District Health Authorities. The transition unit reports to the Deputy Minister of Health on transition matters.

Regional Transition Planning Teams

The transition unit is establishing regional transition planning teams that will enable the unit to work with existing management and staff from the Regional Health Boards and Non-Designated Organizations on the implementation of District Health Authorities. At a minimum, each transition planning team will consist of: Regional Director, Department of Health; Regional Chief Executive Officer; and additional DoH and RHB staff members as required.

- Western Transition Planning Team - transition planning for Districts 1, 2 & 3
- Northern Transition Planning Team - transition planning for Districts 4, 5 & 6
- Eastern Transition Planning Team - transition planning for District 7 (collaboration with the CBHC is required in District 8)
- CBHC Transition Planning Team - transition planning for District 8
- Central Transition Planning Team - transition planning for District 9 (IWK/Grace, QEII, and the Nova Scotia Hospital will participate in this process)

Transition Work Plan

Table 2, summarizes many of the key tasks that must be completed during the transition process and highlights the proposed start and end dates for each task. *The work plan is a planning guide that will be updated and modified as the transition process proceeds.*

TRANSITION WORK PLAN

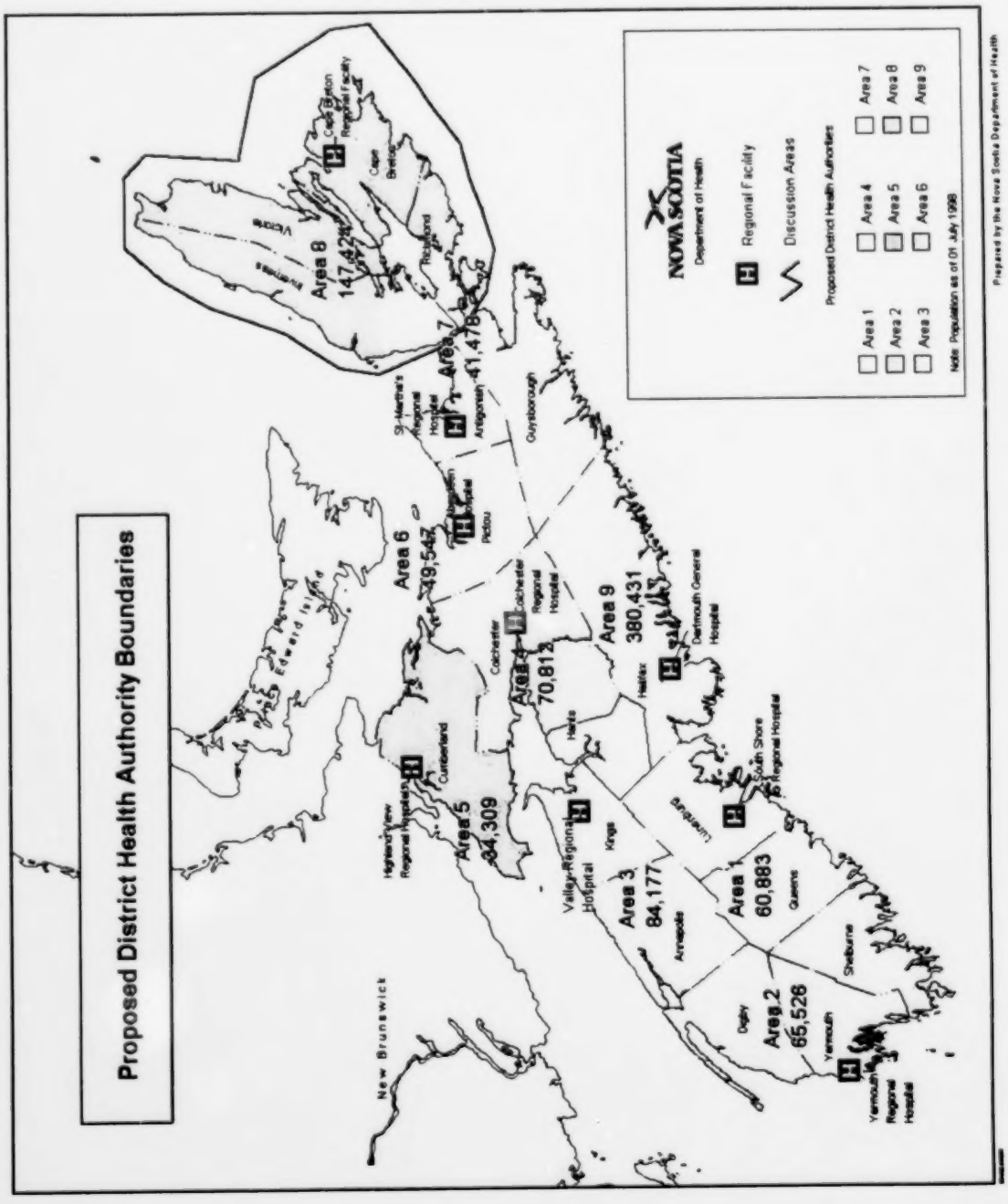
TASK NAME	START DATE (MM/DD/YY)	FINISH DATE (MM/DD/YY)
A.) Establish Transition Unit (TU) and Planning Teams	11/1/99	11/15/99
1. Clarify roles of TU	11/1/99	11/15/99
2. Clarify TU decision-making authority and reporting structure	11/1/99	11/15/99
3. Appoint TU Director	11/1/99	11/15/99
4. Appoint full time staff secretariat to TU	11/1/99	11/15/99
5. Advise all DoH staff of TU role and priority	11/1/99	11/15/99
6. Establish Planning Teams DoH/CEOs from field	11/1/99	11/15/99
B.) Communication Strategy	11/1/99	9/29/00
1. Transition newsletter developed bimonthly	11/1/99	9/29/00
2. Stakeholders meetings every 2 months	11/15/99	9/29/00
3. Targeted labour strategy updates to employees	11/1/99	9/29/00
C.) Prepare provincial clinical services delivery plan	11/1/99	6/20/00
1. Establish clinical services chair, committee and secretariat	11/1/99	12/1/99
2. Define the scope of clinical services to be included in plan	11/10/99	12/21/99
3. Complete inventory of current acute care service in DHAs	12/1/99	1/27/00
4. Analyze implications of 90-day review	12/1/99	1/27/00
5. Prepare utilization and referral information in DHAs	12/1/99	1/27/00
6. Analyze input received from Provincial Health Council Draft Core Services	12/1/99	1/27/00
7. Complete background research	12/1/99	1/27/00
8. Write first draft of provincial clinical services delivery plan	1/28/00	3/27/00
9. Milestone: Preliminary draft of provincial clinical services delivery plan complete		3/28/00
10. Input from DoH/RHBs on first draft of provincial clinical services plan	3/28/00	5/8/00
11. 2nd draft of provincial clinical services delivery plan complete	5/9/00	6/19/00
12. Milestone: Final draft clinical services delivery plan		6/20/00

TASK NAME	START DATE (MM/DD/YY)	FINISH DATE (MM/DD/YY)
D.) Define & legislate new health system structure	11/2/99	5/1/00
1. Articulate responsibilities for DoH, DHAs, PHCCs, NSH, & CHBs	11/2/99	1/31/00
2. Define relationship between QEII & IWK Grace and Halifax DHA	11/2/99	4/28/00
3. Milestone: Relationship between QEII and IWK Grace to Halifax DHA defined		5/1/00
4. Establish structure for delivery of public health & addiction services	11/2/99	3/31/00
5. Write accountability framework for DHAs etc.	11/25/99	3/1/00
6. Milestone: Accountability framework for DHAs established		3/1/00
7. Determine boundaries of DHAs	11/2/99	3/24/00
8. Milestone: DoH recommendation to government re: DHA boundaries		1/30/00
9. Legislation drafted to dissolve RHBs, establish DHAs, legislate CHBs	1/3/00	2/25/00
10. Approval on legislation sought from Legislature/Cabinet	2/28/00*	3/31/00*
11. Milestone: DHA legislation & regulations approved		4/3/00*
** Actual date will coincide with the Spring 2000 sitting of the Legislature.*		
E.) Prepare budgets and business plans for DHAs	11/1/99	3/31/00
1. Review/revise existing service delivery & support service contracts	11/1/99	1/31/00
2. RHB review of foundation issues	1/3/00	1/31/00
3. Preliminary 2000/2001 DoH budget target	12/1/99	2/28/00
4. Interim 6-month budget for RHBs	2/28/99	4/1/00
5. Transition teams develop business plans for DHAs	4/1/00	7/1/00
6. Milestone: Preliminary budget for DHAs		7/1/00
7. Refine DHA budget based on clinical service plan	7/1/00	10/1/00

TASK NAME	START DATE (MM/DD/YY)	FINISH DATE (MM/DD/YY)
F.) Appoint & orient members of DHAs	1/3/00	7/25/00
1. Engage CHBs in selecting 2/3 DHA members from communities	1/3/00	2/25/00
2. Advertise for 1/3 DHA seats via ministerial appointment	1/3/00	2/25/00
3. Screen applications	2/28/00	3/10/00
4. Make recommendations to government appointment cttee	3/13/00	3/13/00
5. Government appointment cttee approves members	3/14/00	4/20/00
6. Determine DHA chairs	4/21/00	4/24/00
7. Milestone: Announce appointment of all members		4/25/00
8. Develop orientation program for DHA members	1/3/00	3/30/00
9. Provide orientation program for new members	4/26/00	7/25/00
G.) Establish DHA administration	11/1/99	10/2/00
1. Option for DHA executive & medical structure discussed	11/1/99	1/21/00
2. Milestone: DHA executive & medical structure recommended to government		1/24/00
3. Develop salary guidelines for DHA executives	1/24/00	2/18/00
4. DHA boards recruit CEOs (appoint interim if needed)	5/15/00	8/4/00
5. CEOs and DHA boards recruit DHA senior management	8/7/00	9/29/00
6. Milestone: CEO & Executive DHA staff recruited		9/29/00
7. Develop and implement labour strategy for transfer of staff to DHAs	12/1/99	9/29/00
8. Milestone: Labour strategy implemented		10/2/00
9. Milestone: DHAs assume governance		10/2/00
H.) Establish CHBs as advisory bodies to DHAs	12/1/99	4/14/00
1. Dialogue with CHBs re: role, support needed, etc.	12/1/99	3/31/00
2. Recommendation re: type of formal support CHBs need at DHA	4/3/00	4/14/00

TASK NAME	START DATE (MM/DD/YY)	FINISH DATE (MM/DD/YY)
I.) **Regular Reporting to Cabinet**	11/26/99	10/31/00
1. Report to Cabinet	11/26/99	11/30/99
2. Report to Cabinet	12/29/99	12/31/99
3. Report to Cabinet	1/27/00	1/31/00
4. Report to Cabinet	2/25/00	2/29/00
5. Report to Cabinet	3/29/00	3/31/00
6. Report to Cabinet	4/26/00	4/28/00
7. Report to Cabinet	5/29/00	5/31/00
8. Report to Cabinet	6/28/00	6/30/00
9. Report to Cabinet	7/27/00	7/31/00
10. Report to Cabinet	8/29/00	8/31/00
11. Report to Cabinet	9/27/00	9/30/00
12. Report to Cabinet	10/27/00	10/31/00

APPENDIX A : MAP OF PROPOSED DISTRICT HEALTH AUTHORITIES



APPENDIX B: QUESTIONS AND ANSWERS

1. How will the quality and level of care be maintained across the province?

Every effort will be made to involve health care providers in the change process to ensure the quality of health care services being provided to Nova Scotians is maintained during the transition. The Department of Health will play a stronger role in setting and monitoring standards. Clear accountabilities will be outlined and information systems will be developed to support decision making, both clinical and administrative. The Department of Health and the CEOs will also be working with the various stakeholders in the system, including the public, to determine appropriate services in each district. This does not mean each district will have identical services, but rather that Nova Scotians, wherever they live, will have reasonable access to all necessary health care services. The DoH will establish a master clinical services delivery plan in collaboration with the field to ensure the broad range of health care services are available as the system moves to nine districts.

2. What is the difference between a District Health Authority and a Regional Health Board?

The prime responsibility of the District Health Authorities will be to integrate the delivery of health care services. The services requiring integration encompass community health, health promotion, illness prevention, hospital (acute) care, emergency services, drug dependency, public health, mental health, home care and long term care. Service integration will make it easier for individuals who require a range of health services to obtain them. DHAs will coordinate the relationships among patients, providers, and health organizations to meet the needs of patients.

DHAs will represent smaller populations than the Regional Health Boards (RHBs) did. In addition, the majority of their board members will be selected by the Community Health Boards instead of by the government, as was the case with the Regional Health Boards. This will give the DHAs a closer connection to communities.

DHAs will be one component of an improved health care system that will deliver an appropriate and comprehensive range of services. The system will focus on the needs of the patient and make it easier for them to access the full-range of health care services, including home care and long term care.

3. How is this system different from the former one?

For patients: Since DHAs will be responsible for integrating service-delivery, patients who require home care, inpatient hospital care, or long term care services will find it much easier to access those services and to move from one service to another as their health care needs change.

For providers: The broad range of health care providers in the system will be supported and partnerships and linkages will flourish. Providers of primary care services will be recognized as the first point of contact for patients who want to access health care services.

For board members, staff and communities: Under the old system, some health care providers and communities felt distant from the RHBs. Under the DHAs, this situation will change. Since the DHAs are responsible for relatively small geographic areas, and the majority of the DHA members will be selected by CHBs, the staff and board members of the DHAs will be very familiar with their districts and the organizations within them, particularly the CHBs.

4. How will the transition from four regional boards to nine district boards save money?

Moving from four boards to nine will not initially result in large savings. The primary reason for creating nine District Health Authorities is to give communities an important voice in health care decisions. Increasing the involvement of communities is expected to make the health care system more responsive to the health needs of Nova Scotians. However, as DHAs evolve, decisions on health care priorities will be based on appropriate care and good outcomes, thereby eliminating waste, duplication, and inefficiencies.

5. How will efficiency be improved?

Efficiency means different things to different people. Individuals who live in communities served by the DHAs will undoubtedly measure efficiency by how well and how promptly their health concerns are addressed. Since the DHAs will be relatively small organizations, decision making will be simplified, thus improving the speed with which concerns are addressed.

Access to the system will also be more efficient as a result of improved service integration. Integration will make it easier for patients to access the full-range of health care services from primary care, to home care, hospital care, and long term care.

Communities will be responsible for the actual planning of their local delivery system. Easier access to services and more appropriate service delivery options will make the system more efficient and affordable. Patients will be able to receive the right service, in the right place, by the right provider.

6. Is this change just for the sake of change?

No. Necessary changes include making the regions smaller, increasing community ownership of the boards, and most important, integrating services. Government will implement these changes in a respectful, expedient, and prudent way to ensure stability of the health care system.

7. When will the transition be complete?

The target date for the new DHAs is October 1, 2000. Transition planning and consultation on long term care and home care will continue after this date and a target date for devolution of these services will be announced.

8. Who designed the new structure?

The government's election platform outlined its intention to replace the existing RHBs with nine boards that are based on the catchment areas of the nine regional hospitals. The Department of Health is engaging RHBs and stakeholders in designing the implementation plan.

9. Who was consulted?

During the previous four years and throughout the election campaign, the government heard from many concerned individuals. The public was consulted on the development of government's health platform and the design of the health system. Government is committed to fulfilling the promises made to the electorate.

10. Who will serve on the new DHA boards, how many members will there be, and how will they be selected?

Each DHA governing board will consist of 10 - 12 qualified volunteers who are willing to contribute their skills to improve health care in their district. Two-thirds of the membership on the DHA will be selected by the Community Health Boards through an open public process, while the remaining one-third will be appointed by the Minister of Health, through the government's public appointment process, to which Nova Scotians can apply. This approach is consistent with that used in several other provinces. Through representation on the DHAs, communities and their Community Health Boards will have a greater say in the health care system.

11. Will there be nine CEOs?

Each of the nine DHAs will require a CEO to manage the resources of the DHA in accordance with the policy and direction of DHA's governing board.

12. What will happen to the four Non-Designated Organizations?

The IWK/Grace and the QEII will be formalized as Provincial Health Care Centres. These Centres will continue to provide children and adults in the province with specialized health care services, on a referral basis. Their role in primary and secondary care will be linked with the Halifax DHA. The Cape Breton Health Care Complex will become part of a District Health Authority for one part of Cape Breton. The Nova Scotia Hospital is participating in a review of mental health services. Recommendations from this review, in conjunction with the Clinical Services Review, will determine the delivery of mental health services in the restructured system. All of these organizations will be fully engaged in the development of the transition plans and the Master Clinical Services Plan.

13. What are the boundaries of the new district health authorities?

Boundaries will more or less mirror the already established county, or municipal lines (in some cases more than one county), but will respect traditional referral patterns.

14. Have names been selected for each of the nine DHAs?

No. The selection of names will be discussed with communities during the transition phase.

15. What services will the DHAs be responsible for delivering?

The DHAs will manage and deliver the health care services currently provided by the RHBs and will be responsible for integrating the other components of the health care system.

16. During the transition period, who makes the decisions that used to be made by the Boards of the RHBs?

The Minister and Deputy Minister of Health will be making the decisions until the new structures are in place.

17. Why was it necessary to immediately transfer governance from the RHBs to the Department of Health?

To ensure stability throughout the transition phase, continuity of health care delivery, consistency of transition planning in all four regions, and minimal disruption to staff of the RHBs.

18. The Minister's Task Force on Regionalized Health Care in Nova Scotia (the Goldbloom Report) made several recommendations on the structure of the health care system. What recommendations did the government accept?

The Task Force Report made many significant recommendations that will be accepted and adopted by the government. For instance, the IWK/Grace and the QEII will be recognized as Provincial Health Care Centres; the Cape Breton Health Care Complex will evolve into a DHA; mental health services will be reviewed and changes to support the delivery of comprehensive, integrated mental health services will be implemented; the community planning role of CHBs will be legislated; and CHBs will select two-thirds of the membership of DHAs.

19. What happens to the CEOs and staff of the RHBs?

Regional Health Board CEOs and staff will remain in place during the transition and will be asked to help establish DHAs. In setting up the new DHAs, any staff affected by such matters as relocations will be dealt with fairly and compassionately.

20. If someone was working for a Regional Health Board yesterday, who are they working for now?

They will continue to work for the RHB until the DHAs are established. The RHB organizations are still in place, only their governance has changed.

21. How will the new structures affect existing collective agreements?

Unions will be kept informed and provincial succession rights legislation will guide migration to the new structure.

22. How will the hospitals be funded?

There will be business planning and budgeting processes established to determine the funding of the health care system, including hospitals. This process will be led by the Department of Health. CEOs and staff will be vital members of the business planning team.

23. How will hospitals be managed?

It is proposed that within the DHA structure, a position should be clearly identified to manage hospital services within the district.

24. What will be the role of the Community Health Boards?

Community Health Boards will be legislated to assess local needs, to develop community health plans on the coordination of primary health care for the District Health Authorities, and to identify ways to improve the overall health of the community. CHBs will select 2/3 of the DHA board members thereby influencing decision-making at the district level.

25. Do Community Health Boards exist in every part of the province?

CHBs exist in all areas of the province except for Industrial Cape Breton. A priority of government is to ensure that CHBs are established in this area as soon as possible.

26. Are all Community Health Boards at the same level of development?

Some CHBs are at a more advanced stage of development than others. RHBs were mandated by legislation to establish CHBs. They did so through an open, public process based on community development, which resulted in some communities coming together to accomplish this task faster than others. Most CHBs have developed their first community health plan and some CHBs are in the process of developing their second plan.

27. Will hospital foundations continue to exist?

Yes. It is anticipated that hospital foundations will see restructuring as an opportunity to strengthen their role within the health districts and the services and hospitals they represent. Foundations may feel closer to the smaller DHAs than they did to the larger RHBs.

28. Will the role of DoH change with the development of DHAs?

The Minister of Health will retain overall accountability for the health care system and will continue to delegate the responsibility to the DoH for setting provincial policy direction, establishing, monitoring and evaluating provincial standards, funding the health care system, and for managing and delivering any services not devolved to the DHAs. The DoH will change only in its role of setting and monitoring standards. These roles will be strengthened and staff within the Department will be realigned where necessary to provide support to the new structures.

29. The size of the population served by the District Health Authorities varies from region to region. Is this a concern?

The role of the DHA is to integrate service delivery within its boundaries, but this does not mean that every district has to be the same size and offer identical services. A master clinical services delivery plan will be developed for the entire province. This plan will ensure that services that do not exist in one district are made available in a neighboring district. Service agreements will be established in those areas where service division between the nine DHAs is inappropriate.

30. Will legislation be required? When?

To implement the structural changes to the health care system by the proposed target date, new legislation will be prepared for introduction in the Legislature during the Spring 2000 (not later than Summer 2000) sitting of the Legislature.